STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING _____ B. WING _____	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	**1325 ROCKPORT RD BOONVILLE, IN 47601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/9/14.

This visit included a Post survey revisit to the State Residential Survey.

Survey dates: January 22, 2015.

Facility number: 002724
Provider number: 155682
AIM number: 200309330

Survey team:
Sylvia Scales, RN-TC
Terri Walters, RN
Dorothy Watts, RN
Amy Wininger, RN

Census bed type:
SNF: 15
SNF/NF 35
Residential: 34
Total: 84

Census payor type:
Medicare:15
Medicaid: 24
Other: 11
Total: 50

Residential Sample: 3

Woodmont Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING _____ B. WING _____	R 01/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	**1325 ROCKPORT RD BOONVILLE, IN 47601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Recertification and State Licensure Survey. Quality review completed on January 23, 2015 by Jodi Meyer, RN	{F 000}		